EXHIBIT: 3
NAME: Bellini
DATE: 2-7-13
Tina Terrell Burney CSR2305

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CORRECTIONAL MANAGED CARE
INTAKE HISTORY AND HEALTH SCREENING

1721640

I. IDENTIFICATION

NAME: McCollum, Larry OCCUPATION: Driver EDUCATION: High School

DOB: 04/04/53 COUNTY: McLennan PREVIOUS TDCJ #(s): ____________

II FAMILY HISTORY					
1 Blood disease (sickle cell anemia, hemophilia)	YES	NO	18 INH Prophylaxis	YES	NO
2 Cancer	YES	NO	19 Intravenous Drug Abuse	YES	NO
3 Diabetes	YES	NO	20 Kidney Disease	YES	NO
4 Heart Disease	YES	NO	21 Liver Disease	YES	NO
5 High Blood Pressure	YES	NO	22 Mental Illness	YES	NO
6 Tuberculosis	YES	NO	23 Non Intravenous Drug Abuse/Alcoholism	YES	NO
III PERSONAL HISTORY			24 Peptic Ulcers	YES	NO
11 D 1 Asthma/Emphysema	YES	NO	25 Rheumatic Fever	YES	NO
2 Back Injury	YES	NO	26 Rheumatism/Arthritis	YES	NO
3 Blood Disease (sickle cell anemia, hemophilia)	YES	NO	27 Seasonal Allergies	YES	NO
4 Cancer	YES	NO	28 Sexually Transmitted Diseases	YES	NO
5 Cavities	YES	NO	29 Smoker	YES	NO
6 Depression/Suicide Attempt	YES	NO	30 Tetanus Immunization Date	YES	NO
7 Diabetes	YES	NO	31 Tuberculosis	YES	NO
8 Drug/ Food Allergies	YES	NO	32 Unprotected Sex w/Multiple Partners	YES	NO
9 Epilepsy/Seizures	YES	NO	33 Other		
		NO	IV OBSTETRIC/GYNECOLOGICAL HX	X	N/A
10 Glasses/Hearing Aid	YES				
11 Gum disease	YES	NO	1 Date of last menstrual period		
12 Head Injury	YES	NO	2 Number of pregnancies/live births		
13 Heart Disease/Angina	YES	NO	3 History of Problem pregnancy		
14 Hepatitis	YES	NO	4 Date of last pap smear		
15 High Blood Pressure	YES	NO	5 Date of last mammogram		
16 HIV + / AIDS	YES	NO	6 History of birth control methods (IUD, pills, etc.)		
Prior HIV Test Date		NO			
17 Homosexual/Bisexual Activities		NO			

A. If YES to any of the above indicate family member or self, give date and treatment received
Father, Brother

B History of hospitalization? YES NO
Please list the DATE, HOSPITAL, CONDITION: Hillcrest Hospital

C. Do you have any current medical, mental health or dental complaints? YES NO
If yes, what: tooth pull, Depression

D. Have you experienced any of these symptoms: cough, weakness, weight loss, fevers, night sweats, loss of appetite or lethargy?
YES NO If YES, when?

E. What illegal drugs have you used? No
What was the mode(s) of use? (Please circle) Smoking Injection Inhaled Ingested
What amount and how often did you use drugs and alcohol?
When was the last time you used drugs or alcohol?
Have you ever had withdrawal or seizures when you stopped using drugs or alcohol? YES NO

F Are you presently taking or supposed to be taking any prescribed medications? YES NO
If YES, what: See Med Sheet

HSM-13 (6/06)

DEFENDANT'S EXHIBIT 2

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CORRECTIONAL MANAGED CARE
INTAKE HISTORY AND HEALTH SCREENING

	Reason for taking medications							
G	Observations	Tremor	YES	NO	Sweating	YES	NO	Other
	Condition of skin	Cuts	YES	NO	Bruises	YES	NO	
		Sores	YES	NO	Other			
	Body & Movement	Deformities	YES	NO	Impaired Motor Activity	YES	NO	
		Other						

H	BEHAVIOR AND MENTAL STATUS											
	Hygiene & Appearance	✓	Clean, neat		Dirty, sloppy		Other					
	Orientation (ask questions and document response)											
	What is today's date?	7/15/11										
	What time is it?	Morning										
	What place is this?	Kwickstar										
	Speech	✓	Normal		Loud		Soft		Mumbling		Other	
	Attitude	✓	Appropriate		Laughing		Crying		Cursing		Quiet	Other

I	THOUGHT CONTENT (Please circle YES or NO)		
	Are you having current thoughts about suicide or self-injury?	YES	NO
	Do you see or hear things that others do not see or hear?	YES	NO
	Do you have any special powers abilities?	YES	NO
	Do you receive personal messages from the TV or radio?	YES	NO
	Do you have any phobias or excessive fears?	YES	NO

J	DISPOSITION								
	Routine referral to	✓	Medical	✓	Mental Health	✓	Dental	✓	CID
	Immediate referral to		Medical		Mental Health		Dental		CID
	Release to general population	✓	YES		NO	Other			

Offender Signature	Larry McCollum	Date	7-15-11
Reviewer Signature	D. Haywood	Date	7/15/11

[signature] RN 7/18/11

HSM-13 (6/08)